PRE-EMPLOYMENT MEDICAL HISTORY QUESTIONNAIRE

Name):	**Date:**
Address:	**Age:**
City/State/Zip:	**Date of Birth:**
Phone:	**Gender:**
Company and Contact:	

MEDICAL HISTORY

If you have received treatment for any medical condition or injury in the **last 12 months** or are you currently under the care of a healthcare provider (physician, chiropractor, pain management, etc.), please provide details of the condition and treatment as well as name and contact info of the treating provider: _____

_____

Please check any of the following you have ever been diagnosed with or treated for. If you have not been diagnosed with anything, please mark none: ☐ None

- ☐ Arthritis
- ☐ Asthma/ emphysema/ COPD
- ☐ Auto-immune conditions (Lupus, Rheumatoid Arthritis)
- ☐ Broken bones requiring surgery
- ☐ Burns
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic pain
- ☐ Color blindness
- ☐ Concussion or head injury
- ☐ Diabetes (Type 1 or Type 2)
- ☐ Hearing issues
- ☐ Heart disease (heart attack, chest pain, heart murmur)
- ☐ Hernia
- ☐ Herniated disc
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Irregular heartbeat (including pacemaker)
- ☐ Kidney disease
- ☐ Liver disease (cirrhosis, hepatitis)
- ☐ Low back pain
- ☐ Mental health disorder (anxiety, depression, PTSD)
- ☐ Migraine or chronic headache
- ☐ Positive tuberculosis test (TB)
- ☐ Seasonal allergies
- ☐ Seizures (convulsions)
- ☐ Stroke
- ☐ Tendonitis or bursitis
- ☐ Other significant illnesses

Please explain any that have been checked: _____

_____

Hospitalizations or surgeries you have had including dates: _____

_____

Please check any of the following symptoms you are currently experiencing or have experienced in the past. If you have no symptoms, please mark none: ☐ None

- ☐ Arm, shoulder, hand injury and/or pain
- ☐ Chest pain or tightness
- ☐ Difficulty, blood or burning with urinating
- ☐ Fatigue
- ☐ Leg, knee, or foot injury or pain
- ☐ Loss of consciousness
- ☐ Loss of grip strength
- ☐ Neck injury or pain
- ☐ Recurrent skin itching, redness, hives
- ☐ Recurring or chronic cough
- ☐ Shortness of breath
- ☐ Tingling or numbness in arms, hands, legs, or feet
- ☐ Trouble concentrating or memory problems
- ☐ Weakness

Please explain any that have been checked: _____

_____

Are you currently pregnant?	☐ Yes	☐ No
If so, please write how far along you are (gestational age):		
Are you currently breastfeeding?	☐ Yes	☐ No

Please list medications you are taking including prescription and over-the-counter medications: _____

_____

Please list any allergies to medication (if no allergies write none): _____

SUBSTANCE USE HISTORY

Please check any of the tobacco or nicotine products you use. If you have never used any of the following, please mark none: ☐ None

☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Vaping

Amount per day:	
Number of years:	
If you have quit, when and how long did you use?	

***Use of tobacco/nicotine products poses significant risk to your health and may lead to irreversible damage to your body. Our advice is that you quit using tobacco products. If you would like information on quitting tobacco/nicotine, please tell your provider.

Are you currently or have you ever been in recovery from alcohol or substance use? ☐ Yes ☐ No

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	☐	☐
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	☐	☐
How many times in the past year have you used a recreational drug or prescription medication for nonmedical reasons?	☐	☐

*Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

OCCUPATIONAL HISTORY

In your job (currently or in the past), please check any of the following you have been exposed to. If you have never been exposed to any of the following, please mark none: ☐ None

☐ Asbestos
☐ Chemicals
☐ Dust (wood, coal, rock, etc.)
☐ Extreme heat or cold
☐ Lasers
☐ Noisy Areas
☐ Organic solvents
☐ Pesticides
☐ Radiation
☐ Repetitive use
☐ Smoke
☐ Vibration (jackhammer)

Please describe any injuries/illness you have experienced because of exposure to the above: _____
_____

Please provide details of any of the following that apply to you:

If you have ever had a work-related injury/illness that caused you to miss more than one day of work.	
Any work restrictions (temporary or permanent) you have ever had.	
Any disabilities that require reasonable accommodations.	

Please check any of the following activities you are unable to do or are limited in doing because of a medical condition or pain. If you have no issues with performing any activities, please mark none: ☐ None

☐ Push, pull, lift, or carry more than 50 pounds
☐ Bending, stooping, or kneeling
☐ Standing, walking, or sitting for short or extended periods
☐ Crawling or cramped conditions
☐ Shoveling, digging, or rowing
☐ Climb ladders, stairs, poles, scaffolding, or ramps
☐ Using arms or legs in full range of motion activities
☐ Working on uneven, slippering, moving, or hilly surfaces
☐ Working at heights
☐ Using tools that vibrate or have a cutting edge
☐ Gripping with either hand
☐ Repetitive motions of hand/wrist or arm/leg
☐ Differentiating colors or depth perception
☐ Wearing a dust mask or respirator
☐ Working around fumes, dust, mists, gases, or dampness
☐ Working in temperatures below 32 or above 90 degrees
☐ Working around electrical current, steam, or moving parts
☐ Working alone or with the public
☐ Working a rotating 1st/2nd/3rd shift
☐ Working more than an 8-hour shift or 40 hours in a week
☐ Irregular meal schedule(s)
☐ Other

Please explain any that have been checked: _____
_____

I certify that the above information, supplied by me, is true to the best of my knowledge, and I understand that providing false or misleading information during a pre-placement medical process may result in disciplinary action up to and including termination.

Patient Signature: _____ Date: _____